Ministry of JUSTICE

Reform of the Coroner System Next Stage

Preparing for Implementation

Response to Consultation

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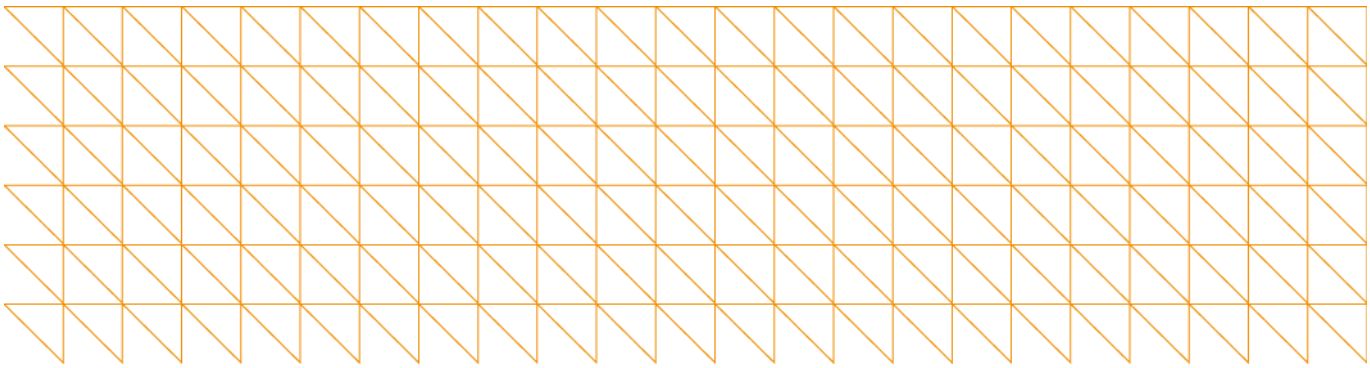

Ministry of JUSTICE

Reform of the Coroner System – Next Stage

Preparing for Implementation

Response to consultation carried out by the Ministry of Justice.

This information is also available on the Ministry of Justice website: www.justice.gov.uk

About this consultation

To:	Coroners and those who work within and who fund the system, voluntary sector stakeholders and the general public
Duration:	From 11/03/2010 to 01/07/2010
Enquiries (including requests for the paper in an alternative format) to:	Hazra Khanom Ministry of Justice 102 Petty France London SW1H 9AJ Tel: 020 3334 6403 Fax: 020 3334 2233 Email: hazra.khanom@justice.gsi.gov.uk

Contents

Contact details

This document summarises the responses to the consultation paper Reform of the Coroner System Next Stage: Preparing for Implementation.

It covers the background to the report and a summary of responses to the consultation paper. Further copies of this document can be obtained by contacting the address below:

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This document is also available on the Ministry of Justice website: www.justice.gov.uk

Alternative formal versions of this publication can be requested from the Coroners and Burials Division.

Executive summary

The consultation paper *Reform of the Coroner System Next Stage: Preparing for Implementation* was published by the Ministry of Justice (MoJ) on 11 March 2010.

It invited comments on a wide range of issues relating to the reform of the coroner system following the Royal Assent of the Coroners and Justice Act 2009 (the 2009 Act). Topics consulted on were:

- Deaths to be reported to a senior coroner;
- Transferring cases from one coroner to another;
- Post-mortem examinations and retention of bodies;
- Coroner investigations – entry, search and seizure;
- Disclosure of information by coroners;
- The conduct of the inquest;
- Appeals and complaints;
- Training of coroners, their officers and staff; and
- Death registration procedures.

The consultation closed on 1 July 2010 and this report summarises the responses to the questions asked in each area. It also includes how the Government intends to take forward each area consulted on, in the light of the responses and the Written Ministerial Statement made to Parliament about the future of the coroner reform programme.

It has been pointed out that the consultation paper made reference to several reports which have informed policy on reform of the coroner system, but it failed to refer to The Isaacs Report, published in 2003, following an investigation by Dr Jeremy Metters. We apologise for this omission.

The Department of Health will be publishing its own consultation paper, seeking views on the details of reform to the death certification system in England and Wales, in Spring 2011.

Summary of responses

Number of responses received

There were 182 responses received. The organisations and individuals that responded can be broken down as follows:

Category	Number of respondents
Coroners, coroners officers and staff	55
Voluntary organisations working with bereaved people	22
Pathologists	8
Professional organisations involved in death certification (registrars)	16
Local authorities	7
Other investigating authorities	6
Bereaved people	10
Police authorities	2
Medical Profession	7
Government Departments and Non-Departmental Bodies	7
Legal Profession	10
Medical Defence Organisations	2
Media Organisations	10
Individuals	10
Faith groups	5
Others	5

The consultation paper asked 69 questions. In broad terms there was support for the aims and objectives of the reform of the coroner system, although there were a variety of views about the detail of how different provisions within the 2009 Act should be implemented. This document summarises the responses received to each question.

Chapter 1 - Deaths to be reported to a senior coroner

Background

This chapter set out proposals for those deaths that should be required to be reported to a coroner by a registered medical practitioner. These were:

- Where there is no attending practitioner or the attending practitioner(s) is unavailable within a prescribed period;
- The death may have been caused by violence, trauma or physical injury, whether intentional or otherwise;
- The death may have been caused by poisoning;
- The death may be a result of intentional self-harm;
- The death may be a result of neglect or failure of care;
- The death may be related to a medical procedure or treatment;
- The death may be due to an injury or disease received in the course of employment, or industrial poisoning;
- The death occurred whilst the deceased was in custody or state detention, whatever the cause of death; or
- The cause of death is unknown.

The chapter then set out that training and guidance would need to be available, and suggested that one option would be for the e-learning package being developed for medical examiners to be made more widely available to medical practitioners. It also proposed that registered medical practitioners who regularly failed to report deaths to a coroner be reported to the relevant Primary Care Trust or medical council and, if not be resolved, the General Medical Council.

Question 1

Do you agree with the cases and circumstances in which a registered medical practitioner must notify a senior coroner of a death? If not, what alternative or additional cases and circumstances would you suggest (bearing in mind the coroner's remit to investigate deaths as defined in section 1 of the 2009 Act)?

There was general agreement with the suggested cases and circumstances, although some concerns remained about how such a list could be implemented and whether its good intentions may be weakened or derailed by variations in local practice or interpretation.

Respondents broadly agreed with the suggested cases and circumstances in which a medical practitioner must notify a coroner of a death. The General Medical Council stated that although there is a common law duty to report a death to the coroner in circumstances where an inquest might be required, a statutory duty to notify a senior coroner of specified types of death is uncontroversial and logical.

However, there were some concerns as to how such a system would be implemented and interpreted. For example, one respondent believed that a list system of deaths to be reported would not work as variations could creep in depending on jurisdiction and individual interpretation. The Medical Protection Society suggested a category of "unexpected death" as this would allow for deaths that occur without any suspicion of human culpability and help to avoid any suggestion that coroners should be determining matters of civil negligence in the case of individuals.

The Coroners' Society of England and Wales ('the Coroners' Society') were strongly in favour of a statutory responsibility to report. However, in view of the proposed introduction of Medical Examiners they had some concerns about how the system would work in practice. All deaths will have to be reported to a medical examiner or a coroner, as a death could not be registered without their authority. In the Society's view, neither the medical examiner nor the coroner could establish a 'reportable death' if the attending doctor did not provide full information, and there needed to be a mechanism to achieve this.

Action against Medical Accidents (AvMA) were concerned that by using the term 'state detention', the 2009 Act would exclude the elderly, long term disabled, those that are too severely ill to consent to their admission to an institution but are still in the care of the state, and voluntary psychiatric patients, from an automatic coroner's investigation. In their view, those circumstances increased the state's responsibility to keep those patients safe and yet they were excluded from these provisions. They also argued that the duty to investigate should apply to those who are in private residential care (such as elderly care homes) as they are also vulnerable persons.

Some coroners suggested that it was important that an unnecessary amount of bureaucracy was not created in the new system, whilst the Association of Chief Police Officers (ACPO) felt that the category of death by neglect should include what it referred to as 'self-neglect'. ACPO felt that this would enable valuable lessons to be learnt regarding social care issues, especially in respect of elderly people.

The Independent Advisory Panel on Deaths in Custody responded that they felt that deaths in prisons, police custody, immigration detention centres, approved premises, secure training centres, secure children's homes, those who die whilst compulsorily detained under mental health legislation, those released on temporary licence and those released from custody within the previous 7 days should all be covered under any such proposal.

In addition, many other suggestions were made by a variety of respondents about the illustrated cases and circumstances and how they could be reworded.

Question 2

We would welcome comments on the draft guidance for registered medical practitioners which explains the cases and circumstances in which a senior coroner should be notified of a death. In particular, short illustrative examples that could be used in guidance would be helpful.

A number of respondents provided comments and examples, including existing versions of similar training material.

The Coroners' Society enclosed with their response a copy of documentation which forms the basis of their e-learning session for medical examiners, written by a currently serving coroner, for the Department of Health. The training material provides guidance on what types of deaths are reportable to coroners, and also provides some clarity between the roles of the coroner and the medical examiner.

The following were among the comments received from other respondents:

1. If a death is not from a natural cause it needs to be reported in all cases.

2. Concerns were raised about deaths caused by poisoning as an increasing number of substances that are not illicit drugs are prescribed over counter. There was a suggestion that the list of illicit drugs could be expanded for these purposes to include those proscribed under Misuse of Drugs Act 1971 and other substances taken for recreational purposes implicated in the death. This would capture substances where there was a public debate on whether they should be proscribed and also alcohol in relation to binge drinking or alcohol poisoning.

3. Concerns were raised about state detention. Respondents asked if consideration could be given as to whether this should include Deprivation of Liberty Orders under the Mental Capacity Act 2005 and secure accommodation orders under s25 of the Children Act 1989 (the latter is not the same as secure accommodation of a young offender).

4. Guidance on "the cause of death is unknown" would need to be carefully written if over-referral to coroners is to be reduced.

5. It will be important to ensure that the guidance is both clear and accessible.

6. Where there is doubt a referral of a death should be made to the senior coroner. Medical practitioners need to be reminded that the illustrated cases and circumstances are for guidance purposes only.

7. There is a need for clarification that where a case may be related to a medical procedure or treatment, the circumstances include not only treatment but also the absence of treatment.

Several respondents welcomed the guidance. Action against Medical Accidents said that the proposed guidance would achieve consistency of approach across England and Wales. Similarly, the Criminal Bar Association described the guidance as helpful and the categories as comprehensive. However, they did not want the guidance to be interpreted too "tightly". Concerns were raised that the guidelines appeared to be unduly complicated and could therefore either be misinterpreted or would be more likely to be ignored - and as a result this could lead to further inconsistencies and missed opportunities.

Question 3

Given new ways of delivering health services, particularly to the terminally ill, should the time period for a death to be automatically reported to a coroner be extended to 28 days, from 14 days, of a doctor not having attended the patient? Or should there be no time limit at all?

There was greatest support for an extension to 28 days, although there were also calls for an extension to only 21 days or the introduction of signing by a second doctor who had seen the deceased person within the past 28 days if a doctor who had seen them within the past 14 days was not available.

Respondents from a medical background, such as the General Medical Council, doctors and pathologists, generally supported extending the time limit to 28 days. The Coroners' Society felt that 28 days would be a reasonable period, although they did not believe that this would cut the post-mortem examination rate as such cases were invariably concluded following discussion with the deceased person's doctor.

However, not all coroners agreed with the Coroners' Society, with one suggesting that a great deal can change in a patient's condition within 28 days, as there has been a large increase in patients dying at home or who are placed on "Care of the Dying Pathways".

A few respondents stated their belief that there should be no time limit at all. One registrar suggested that there should be a secondary timeframe. This would retain the 14 day rule but where the doctor is unavailable to sign, another doctor who has seen the patient within the last 28 days would be able to do so.

Question 4

What channels should be used to provide training and guidance for medical practitioners on the cases and circumstances in which a senior coroner should be notified of a death?

There was general support for basic training at medical schools for those medical practitioners currently coming through the system, and for e-learning and continuing professional development for those who have already qualified.

Most respondents agreed that training and guidance should be provided to medical practitioners at medical school, so that this can form the basis for future development. Respondents also suggested that medical practitioners could continue to develop their skills and knowledge by going on more training courses, e-learning, workshops, conferences and through their continuing professional development. One respondent suggested that prior to implementation there needed to be seminars/workshops, organised in liaison with all agencies involved with deaths, to allow them to share information amongst themselves and clarify precisely when cases have to be referred.

The Coroners' Society said that the Department of Health had made it clear that all doctors (and others such as registrars and coroners) would in future have access to the (increasingly extensive) e-learning material that is being prepared for medical examiners, which has significant coroner input. Furthermore, they believed that the very existence of medical examiners would provide a consistent and ready source of guidance/training for medical practitioners over time. Where time permits they would like coroners to become involved in induction training for new medical intakes.

Question 5

Do you agree with the proposed arrangements for dealing with registered medical practitioners who consistently or deliberately fail to notify a senior coroner of a death(s)? If not, what alternative arrangements – short of creating a new offence – would you suggest?

The proposed arrangements were generally seen as reasonable, with those who repeatedly failed to report deaths, and respond to the offer of training to be subject to a full investigation at the hands of the General Medical Council.

The majority of respondents agreed that the proposals seemed reasonable for dealing with medical practitioners who consistently or deliberately failed to notify a senior coroner of a death. The General Medical Council were supportive of the suggestion that where a doctor repeatedly failed to report deaths, and failed to respond to offers of training, the doctor should be reported to the General Medical Council, who would then conduct a full investigation.

One coroner stated that, notwithstanding the way the question was phrased, he would like to see the creation of a new criminal offence to deal with such circumstances. A small minority of respondents agreed with this view.

Chapter 2 - Transferring cases from one coroner area to another

Background

This chapter set out proposals for how transfers would work within the new system. It listed a number of circumstances in which it was envisaged transfer may happen, suggested that the originating authority should usually continue to meet the expenses of the inquest and suggested that regulations set out the process for incurring and paying expenses in transferred cases, and for notification of transferred investigations.

Question 6

The circumstances, other than those set out in the consultation paper, when consideration should be given to cases being transferred.

Overall there was support for the principle of transfer (although a minority did not agree) but not at the expense of the efficiency of the service. A range of views were expressed as to the types of cases that were appropriate for transfer.

Some agreed with the circumstances where cases should be transferred, and some agreed but with caveats. A number did not comment on when cases should be transferred, but wanted the process to be kept as simple as possible. One coroner suggested that transfers should not be made solely for the convenience of family members, as there are other considerations, such as the proximity of witnesses which would also need to be taken into account. This point was also made by the Bereavement Advice Centre, emphasising that although the needs of the bereaved were important, the efficiency and effectiveness of the investigation should not be impaired by the transfer of a case. The Coroners' Society had concerns about categories, and suggested two further categories for inclusion. Lancashire County Council Registration Service were concerned that transferring cases could impact on a coroner's workload, resulting in local inquest cases being delayed.

In general terms, bereaved family members and voluntary organisations such as the Coroners' Courts Support Service and Cruse Bereavement Care were very supportive of allowing coroners to transfer cases from one jurisdiction to another. Many respondents also said that a good reason for transfer would be when one coroner has particular expertise and would therefore be in a better position to conduct the investigation.

Question 7

'Who pays' in circumstances where an investigation is transferred whether on the direction of the Chief Coroner or by agreement between the coroners concerned?

There were mixed views amongst respondents. The majority of coroners were in favour of the recipient authority being responsible for paying. However, amongst other respondents the costs remaining with the authority requesting transfer was generally welcomed.

Many respondents agreed that the office requesting the transfer should pay. The Local Authority Managers groups for coroners in the South East and East Midlands felt there should be also be the ability for specialist hospitals to transfer cases to the home jurisdiction of the deceased to spread the financial burden. Action against Medical Accidents felt that where a district had an unusually high number of cases, additional resources should be provided to manage demand rather than there being an exception to the rule that the originating authority should pay.

However, of those coroners who responded, the majority felt that the recipient authority should pay. This view was shared by the Coroners Officer's Association who highlighted concerns about districts where there is a hospital which houses a specialist unit, and frequently treats people from other districts. A large number of these types of cases could result in additional costs for the coroner (and thus the local authority) covering that hospital.

Other suggestions included one of costs being agreed by negotiation between the two local authorities; another that coroners should agree the division of costs amongst themselves; while one respondent suggested that it might be fairer to split the costs between the two jurisdictions.

Question 8

We would welcome your views on the process of notification of transferred investigations that:

- **Coroners A and B must agree at the time of transfer which of them will confirm in writing, to any identified interested persons, that the transfer has taken place, and write to those interested persons within five working days.**

- **Coroner A must give Coroner B the relevant paperwork within five working days of receiving the direction from the Chief Coroner.**

Most agreed with the proposed process although there were some comments, notably from coroners, who suggested it was too complicated.

Most respondents agreed with the proposed process of notification of transferred investigations. The Royal British Legion felt that five working days was an adequate timescale, but that communications should outline the detailed reasons for transfer to the interested person and that this should be included in regulations. One coroner felt that five working days was sufficient, but there should be discretion to extend this timescale in complex cases. Some, including some coroners, felt that the present system works well and that the proposed process was too bureaucratic.

Chapter 3 – Post-mortem examinations and retention of bodies

Background

This chapter explored a wide range of issues related to post-mortem examinations. It discussed the purpose of a coroner's post-mortem examination (suggesting that the purpose is to provide the coroner with sufficient information to carry out his or her legal duty of establishing the cause of death), as well as recognising that there may be other information to be gleaned that may be desirable. It set out a number of areas that were proposed to be taken forward which are currently dealt with in rules or in case law.

There was also discussion of the retention of the body or body parts in relation to the Human Tissue Act 2004, and in particular the requirement for consent of the next of kin to be obtained for retention of human tissue, unless it is held for the purposes of the coroner or under other legislation. If consent is not received within 3 months, it was proposed it should be destroyed. The paper recognised that occasionally bodies were retained for a very lengthy period which can create added grief for the bereaved family.

Finally, it set out the subjects that were likely to be contained in the new regulations and those subjects likely to be contained in guidance.

Question 9

What do respondents consider to be the purpose of a coroner commissioned post-mortem examination?

Most agreed that the purpose of a coroner commissioned post-mortem examination should be to establish the cause of death, and whilst other findings may be desirable and helpful, they were not part of the coroners remit. A minority suggested that coroners' post-mortem examinations could be used to provide information for families and wider public health policy.

It was generally agreed amongst the respondents that the purpose of a coroner commissioned post-mortem examination was to establish the cause of death to a reasonable but not absolute degree of certainty.

The Coroners' Society suggested that the main purpose of an autopsy is to establish the absence of violence and unnatural causes of death and, beyond that, to assist the coroner in establishing the underlying medical cause of death. For more extensive investigation the autopsy should be consented. One coroner expressed the view that the purpose of such a post-mortem examination was to identify who died, and by what means the deceased came by **the** cause of death - it was not to find **a** cause of death. It was explained that although someone may have a fatal condition, it does not necessarily mean that that condition caused the death - for example a person with significant ischaemic heart disease, if shot through the head, would have died

of the head injury and not the heart disease. It is for these reasons that there should be fewer autopsies but those which are carried out must be comprehensive and thorough.

The British Paediatric Pathology Association agreed that the purpose of the post-mortem examination was to establish the immediate cause of death but there may also be wider questions that require answering such as the likelihood of a similar death occurring in the family due to genetic defects. The Royal College of Pathologists were of a similar view, suggesting that, whether a post-mortem examination is carried out for the coroner or not, one of the benefits of holding one is that it provides information for the benefit of the living. Aside from identifying inherited diseases, they could also help to inform future public health policy, as well providing information that supports clinical audit and review.

Cardiac Risk in the Young felt that particularly for cases of 'young sudden cardiac death' post-mortem examinations played an important role in collating statistics and identifying any genetic implications.

Question 10

In addition to ensuring greater consistency in the commissioning of post-mortem examinations, how may the number of post-mortem examinations be reduced?

The majority suggested that the focus should be on ensuring that only those post-mortem examinations that are absolutely necessary should take place. Suggestions included better use of training for coroners and medical practitioners alike.

Most respondents were of the view that the aim should not be reducing the number of post-mortem examinations being commissioned, but instead on ensuring examinations only occur when necessary.

It was generally agreed amongst respondents that the rate of post-mortem examinations would be reduced if coroners and doctors were given better training. In addition, many also believed that the introduction of Medical Examiners would have some effect on the current system. The Royal College of Pathologists stated that there is a near consensus that some autopsies carried out for the coroner are superfluous and that these include cases performed because there is no doctor available who has seen the deceased in the last 14 days.

It was felt by many that the history and circumstances of each particular case needed to be considered, for instance was there any suspicion of homicide, was the person of old age, an alcohol or drug abuser, was there a history of illnesses etc. One individual, an ex-policeman, who witnessed many post-mortem examinations during his lifetime, was of the view that where the person has died in a road traffic collision, by drowning or had committed suicide it should not be necessary in most cases to carry out any further

invasive examination of the body. One coroner felt that in cases of death as the result of a road traffic collision, if the deceased had been seen by a doctor who had given confirmation that death had been as the result of multiple injuries, a medical report to that effect should be sufficient without the need for a post-mortem examination by way of autopsy. If considered necessary reliance on Computerised Tomography scan results to confirm the injuries should be permissible.

Question 11

Should consultation with the relevant next of kin about the examination occur, as a matter of best practice, before the examination takes place (except in cases of suspected homicide)?

Most felt that the next of kin should be informed about post-mortem examinations on their deceased loved ones, and the reasons why such an examination is necessary, wherever possible – but it should be made clear that the decision as to whether such an examination is required or not is solely for the coroner to determine.

There was a mix of views on this issue but there was greater support for the next of kin to be informed, rather than consulted, about a post-mortem examination. A number of respondents felt that it would not help improve the current situation, as it would result in unnecessary delays. It was also suggested that it may create a false impression that they were able to 'veto' a post-mortem examination taking place which should not be the case – the coroner must have the last say as to whether a post-mortem examination was carried out or not. One coroner suggested that the family should be "advised" rather than "consulted", as a consultation suggests that there is a choice or a veto. If there was a choice, then there could be a future situation where there would be no post-mortem examinations other than those carried out for criminal cases and this would not be in the public interest.

However, there were a number who agreed with the principle of consultation. Voluntary organisations, such as Victim Support and Cruse Bereavement Care thought it was essential that the next of kin were consulted about the examination, as it gave them an opportunity to understand the reasons for, and express their views regarding, the carrying out of a post-mortem examination on their deceased relative.

The Human Tissue Authority supported extensive communication with the next of kin before the post-mortem examination taking place, in order to ensure that discussion about what should happen to retained tissue began early and thus enabled fully informed decisions to be reached by the family. The Independent Advisory Panel on Deaths in Custody said that some families had reported to them that they had only found out about the post-mortem examination after it had taken place, whilst others had only found out on the day itself. The Panel agreed that consultation with the relevant next of kin about the examination should occur before the examination took place as

a matter of good practice, and that the procedure by which coroners would make such consultations should be formalised.

Question 12

Where it has not been possible, for whatever reason, to obtain such consent [from the next of kin for retention of tissue], how should matters relating to tissue retention be dealt with? Does the current 'three month rule' work in practice? Should the three months begin from the date of the conclusion of the examination?

There is general agreement over the three month period – although no consensus as to whether that period begins from the conclusion of the post-mortem examination or the conclusion of the inquest.

Many respondents agreed that three months is an appropriate period - however, there was disagreement amongst them as to when the three month period should begin. A majority who supported the three month period believed it should commence from the date of the conclusion of the examination, but a significant minority believed it should commence from the conclusion of the inquest. Two coroners suggested that there was some confusion in this area, and there was an urgent need for clarity. One pathologist argued that the three month rule should be abolished and that all tissues and specimens taken during the course of a coroner commissioned post-mortem examinations must form part of the permanent medical record. This, he argued, was because relatives did not always understand at the time the value of retained tissue and how it might be important for their own medical care. Cardiac Risk in the Young argued that in all cases of 'young sudden cardiac death' tissue retention should be mandatory because of the possible genetic implications of the death in question.

Question 13

When might a coroner wish to consider authorising a post-mortem examination to be carried out by a less invasive method?

Although many respondents were not convinced of the validity of such examinations, there was some support for such examinations to be considered where such techniques could accurately ascertain the cause of death with more limited support where there were strong cultural or religious reasons for doing so.

There were mixed views amongst respondents on this issue. Many respondents appeared to be sceptical of non-invasive techniques and were of the impression that fully invasive post–mortem examinations by way of autopsy were currently and would remain the best option when it came to accurately investigating and establishing the cause of death, until evidence could prove otherwise.

Those respondents who were more in favour of non-invasive techniques argued that they should be used where the cause of death is likely to be found in a specific area of the body, in cases where there is no criminal suspicion, in cases where the deceased person is deemed to be highly infectious and a risk to health professionals, or where there is evidence that an alternative method will produce reliable evidence as to the cause of death.

One coroner's officer was of the view that non-invasive methods should be used for cultural or religious purposes or where the family offers strong objection to a full post-mortem examination. A coroner said that if less invasive examinations are to be carried out then there should be very clear rules about when they should be carried out. The Human Tissue Authority stated that coroners should give regard to the relatives of the deceased's cultural and religious concerns when determining whether a fully invasive post-mortem examination was necessary. Both the Bolton Council of Mosques and the Muslim Burial Council of Leicestershire welcomed the possibility of using non-invasive techniques where post-mortem examinations are required. Where this was not possible, they would like the coroner to be under an obligation to inform the families of the reasons why.

Others expressed the view that there needed to be further clarification about who would actually have to cover the costs of moving the body from one location to another for the purposes of a less invasive post-mortem examination and then back again once the examination had taken place.

Question 14

Who might be designated as suitable to conduct post-mortem or related examinations if they are not registered medical practitioners?

There was no great support for further designations of suitable persons to carry out post-mortem examinations.

Many agreed that only fully trained mortuary staff and those with specialist skills should carry out post-mortem examinations. A few respondents believed that only qualified pathologists should carry out such examinations. One histopathologist had serious concerns about anybody other than a pathologist carrying out post-mortem examinations, as they are the only practitioners who are formally trained and qualified in doing so, and allowing them to put the death into context. Even if a non-medical practitioner could be trained to do such examinations, a lack of medical knowledge would be a serious impediment to being able to see the process in its proper context.

Question 15

Do respondents agree that, providing a body has been identified, 30 days should be the maximum time by which a body of someone who has died should be released for a funeral?

There was general support for a 30 day release period, although recognition that this may not always be possible and there would from time to time need to be an exception.

The majority agreed with the 30 day period. However, a number of those respondents also suggested that this may not always be possible to achieve due to the circumstances of an individual case.

Those respondents who disagreed wished to see an extended time limit, with a couple of respondents suggesting a 60 day period, as they are concerned that the 30 day period was not acceptable in, for example, murder cases. Some respondents suggested that although a 30 day period would be desirable it should not become mandatory. There should not be a prescribed time period as there could be good reasons to retain a body for future examinations.

By way of illustration of this issue, and during the course of this consultation, other cases have been brought to the attention of the Department. In one, the bereaved family of a victim who died in February 2010 had been told that they would probably not have the body of their daughter released to them for burial until January 2011 pending further post-mortem examinations requested by the suspect's defence team. In another, the bereaved family of a victim had her funeral postponed on a number of occasions at very short notice due to further post-mortem examinations being requested by the suspect's defence team.

We have also been made aware of a third case where the family had to wait over three months before the body of their son was returned to them, having been subjected to three post-mortem examinations at the request of defence lawyers.

Question 16

Do respondents have any views as to what the format and contents of the post-mortem request and report forms should be in future?

The current forms were generally felt to be adequate although there was some support for a standardised form with a number of suggestions as to what this should contain.

Many of the respondents felt that there was no need to change the current forms. There were, however, some respondents who would like to see more information included in the forms and would like a more standardised format. This was supported by some coroners, with one recommending the adoption

of the format provided by the Royal College of Pathologists, and another providing a pro forma post mortem examination form they currently use.

The Royal College of Pathologists themselves suggested that a report should summarise the preceding circumstances and a description of the findings in each body system. It should then correlate these findings with the circumstances, indicate whether the death was due to natural causes and describe the cause of death in the format required by the Office of National Statistics.

There was a comment that such forms need not include details such as the deceased person's address or occupation, as this was too personal and not necessary, and that there should be some clarification with regard to the need (or otherwise) for the deceased's religion, and indeed that of the next of kin, to be included on the papers.

Chapter 4 – Coroner investigations – entry, search and seizure

Background

The 2009 Act provides for new powers of entry, search and seizure for coroners during the course of an investigation. This chapter outlined the need to ensure suitable protocols be established between coroners and other investigatory bodies, discussion of the relationship between the police and coroners in such circumstances, and set out proposals for regulations to govern how search and seizure will work (coupled with the broad provisions in the 2009 Act). In broad terms this envisaged a mirroring of those described in the Police and Criminal Evidence Act 1984, and then set out potential topics for regulations to cover.

Question 17

Who do coroners envisage carrying out these functions on their behalf? Do coroners envisage delegating this task to coroners' officers, the police, or someone else entirely? Who do other consultees feel should carry out this task on behalf of the coroner? Who do you think would be suitably qualified to carry out this task on behalf of the coroner?

It was generally agreed that coroner's officers and the police should carry out this work on behalf of coroners.

The majority of the respondents identified coroner's officers and police officers as suitable people who could be delegated the power of entry, search and seizure by coroners. The Coroner's Officers Association felt that it should be a person who fully understands the purpose and scope of a coroner's enquiry, who is appropriately trained with suitable experience. They suggested a 'designated coroner's investigator'. The Independent Police Complaints Commission (IPCC) said that where an independent investigation is being carried out, it would not be appropriate for the police to carry out these powers of entry, search and seizure on behalf of the coroner. In those circumstances, the IPCC felt that it should be the IPCC's own investigators who should exercise those functions on behalf of the coroner, or alternatively that they should be exercised by the coroner's officers with the agreement of the IPCC.

Question 18

Should the person entering, searching and seizing have in their possession, in every circumstance, some form of identification stating their authority to be on the land or premises and to remove items and documents?

It was generally agreed that those carrying out this function should have some form of identification detailing their authority to enter and search land or property and seize items or documents.

The majority of respondents agreed that the person entering, searching and seizing should have in their possession some form of documentation stating their authority to be on the land or premises and to remove items and documents. One respondent did not believe that such authority would have to be limited to paper. A coroner suggested that such authorisation should not need to be a paper document from the Chief Coroner. In their opinion, the Chief Coroner could authorise the coroner to enter and search the premises by telephone, the coroner could then record on a warrant this has been authorised and then delegate to the coroner's officers and police officers the authority to execute the warrant.

Question 19

We propose that the procedure for obtaining permission to carry out a search, and the process for carrying out search and seizure, should where possible mirror the process used by the police in accordance with the Police and Criminal Evidence Act 1984 [PACE]. This could be achieved by way of a code of practice, as was proposed during Parliamentary debate on this issue. Do you consider this approach is appropriate?

There was general support for a code of practice.

The majority of respondents agreed that the procedure should mirror the process used by the police in accordance with the PACE, by a way of code of practice. One respondent wanted further information on who would pay for and provide further training on these procedures. One coroner's officer raised concerns about the procedure being contained in a code of practice as it would be more open to non-compliance. The officer concerned would prefer to see the process being contained in secondary legislation rather than guidance, as it would have a stronger basis in law and therefore less open to being ignored.

Question 20

Do you have views on the other aspects of the proposed procedure for entry, search and seizure as set out in Chapter 4?

Most respondents had no further views.

The majority of respondents had no further views on the other aspects of the procedure. However, some suggestions were made. It may be useful to extend the circumstances in which these powers could be used to those situations where no next of kin can be identified, as this would provide access to address books, telephone bills etc. which may provide clues to trace the next of kin. Further information was sought on what would happen if the warrant is executed and the property is damaged and whether the Chief Coroner's crown immunity would cover the coroner and the coroner's area.

Question 21

In normal circumstances, should some form of notice be given to the landowner / occupier that entry, search and seizure is to be undertaken? Is 48 hours a suitable period of notice?

It was generally agreed that no notice was required – although in those circumstances where it was felt that notice should be given, 48 hours was felt to be an adequate period of notice.

The majority of respondents supported the view that the presumption should be that no form of notice should be given. They feared that if notice was given, it would result in evidence being destroyed and would therefore defeat the whole point of introducing a process of entry, search and seizure. ACPO supported this, suggesting that the routine giving of notice could frustrate the purpose of the search and result in the loss of vital evidence.

The few respondents who agreed that notice should be given to the landowner/occupier believed it should be the case that notice should be required except in emergency situations, and 48 hours was a suitable period.

Chapter 5 – Disclosure of information by coroners

Background

This chapter invited comments on the proposed new disclosure regime to help decide what should be included in secondary legislation and what contained in guidance. It included five areas that were intended to be covered:

- Clarity about what may or may not be disclosed and when;
- Ensuring consistency of approach in disclosure practices between coroners;
- Ensuring that all interested persons, whether family members or not, have a right to request information;
- Factoring in all relevant legislation and case law as it applies to organisations whose reports may be considered for disclosure by a coroner; and
- The resources needed to disclose information.

The general principle that coroners should disclose information, on request, to interested persons was set out. A few exceptions[1] to this general principle were also outlined. Disclosure was not intended to be automatic, although interested persons would be made aware of their right to request disclosure. Finally, it was intended that disclosure be free of charge to family members, although regulations may give the power to charge other interested persons.

Question 22

Do you agree that we have captured the right principles and struck a proper balance between those which compete?

There was broad support for the principle of greater disclosure, but mixed views about the extent to which it should apply.

The vast majority of respondents agreed with the need for greater disclosure of documents. A number of respondents expressed the opinion that the proposed reforms placed greater emphasis on the bereaved and do not give the same treatment towards properly interested parties (PiPs). This appeared to be the consensus amongst coroners and coroner's officers. BUPA Care Homes made the same point, suggesting that interested parties may be involved in regulatory inquiries and would need the same rights in accessing information. A number of concerns were expressed about the impact that disclosure may have on other, ongoing investigations. One coroner suggested that care needs to be taken to ensure that the disclosure of material does not make potential witnesses targets for other investigations.

The Health and Safety Executive welcomed the recognition that increased release of information should not adversely impact upon legal proceedings to

[1] Such as legal reasons, or disclosure policies of other organisations who would be providing the material.

be taken after the inquest. Several respondents felt that coroners be either given the power of discretion when it comes to disclosure or there should be some distinction drawn between the types of information that can be disclosed.

The Media Lawyers Association and the Newspaper Society felt that the proposals do not take account of the need to make sure that the media are kept properly informed as to the information that is provided to the bereaved and where the information is not to be made public, why it is not.

Question 23

Should we permit requests to be made at any stage in a coroner's investigation? If so how long should coroners be given to respond to requests, in order not to delay investigations but to provide them with workable timescales?

Most agreed that a request could be made at any time but there were mixed views about how long a coroner should be given to respond and the way in which information should be made available.

The National Offender Management Service suggested that it would be helpful if disclosure could be completed prior to the start of the inquest, as otherwise this may lead to unnecessary adjournments and delays. The Independent Advisory Panel on Deaths in Custody agreed with this, whilst recognising that this is not always possible, and emphasised the need for clear guidance on when and how disclosure will be made. Several respondents suggested that there should be time limits for when requests for disclosure can be made, while others suggested that requests should be allowed once a full hearing has been listed and the coroner has gathered all the information.

Many of the voluntary organisations that responded would like requests for information by bereaved families to be permitted at any time during the investigation. The Coroners' Society also felt a request could be made at any time, but that it should be for the coroner to make a decision about it – there may be a variety of reasons why disclosure to a rigid timescale is not possible.

Amongst the lawyers and legal groups that have responded, a number suggested a list of documentation be made available for disclosure to be provided to bereaved families and their representative. For example, the Birmingham Law Society said, in order to avoid an excessive burden on administrative staff, they would recommend that the list of documents provided to the bereaved only contains those that are relevant and will be relied upon by the coroner during the course of his investigation. They also suggest that there should be a list of unused material provided to families and legal representatives on request.

The Health and Safety Executive advocated the presumption that the coroner does not disclose any material to interested parties until after other investigations by regulatory bodies are completed. The coroner should also be

required to consult with such enforcing authorities before agreeing to any request for disclosure to ensure it does not impact on other future legal proceedings.

Question 24

What do you expect the level of take-up to be of the Charter for Bereaved People's provision for information to be disclosed to bereaved people, free of charge? How would it compare to current requests?

Most respondents felt that that the Charter would lead to an increased level of requests for disclosure.

Most respondents felt that raising awareness and providing information free of charge will significantly increase the level of take-up compared to the present system. Inquest and the Inquest Lawyers Group expected a good take-up by families, with the effect that there would be greater confidence in the openness and transparency of the system. One coroner suggested that the opportunity would be taken in every case, and Cruse Bereavement Care stated that, whilst it was difficult to predict, they anticipated that many families would request information. The Royal British Legion suggested that whilst there would be at least a small increase in requests for disclosure they would expect fewer deaths would be referred to the coroner. Along with guidance to families about what can be requested, this would help to reduce the number of spurious requests for documentation.

That it would result in an increased take-up was not a unanimous view, with a minority contesting that the impact would be minimal. One coroner's officer believed that there would be little difference as at present if the families wish to obtain such information they do so regardless of the cost.

Question 25

Are there any circumstances where bereaved people should pay for disclosure of material?

A wide range of views were offered, with a number of responses suggesting a variety of different circumstances in which it may be appropriate, particularly for requests for duplicate copies. There was also support for the view that it was never appropriate to charge the bereaved. There was little support for charging as a matter of course.

Some responses recognised that there were circumstances in which it may be appropriate to charge. The main suggestions are summarised below:

- Once a copy has been provided and lost or damaged, or where duplicates are requested;
- Where clearly vexatious or unreasonable requests are made;
- Material outside the terms of the Charter;
- Where disclosure involves a high number of documents;

- Distant relatives of the bereaved;
- Where documents relate to older cases.

The general consensus amongst coroners was that, whether it was appropriate to charge or not, the same rule must apply to both bereaved family members and other PiPs.

Some respondents also felt that it was never appropriate to charge. One respondent expressed the view that charging for disclosure would run counter to the Freedom of Information Act (FOIA), and could not see any circumstances, other than existing exemptions under the FOIA, where a charge could apply. There was strong support in the voluntary and, to a lesser extent, legal sectors for the principle that it was never appropriate to charge the bereaved. The British Lung Foundation suggested that it is already difficult for bereaved families, and charging would be insensitive. The Association of Personal Injury Lawyers also felt that information should be made freely available, but where coroners had no choice but to charge then this should be a nominal fee, intended as a gesture of good will.

Question 26

What would the impact be on coroners and their staff of disclosing information free of charge, to bereaved people and possibly to other interested persons? What would the costs be and how would those costs be comprised?

Most agreed that there would be an increase in the workload and costs for coroners although there were some differences in how significant and how these may be mitigated.

The broad consensus amongst local authorities and coroners was that disclosure would have significant resource implications. One coroner suggested that there would be a substantial increase in workload for both coroners and their staff and that it was a task that required utmost care as the incorrect disclosure of one sensitive document 'is a potential disaster'. A local authority suggested that it would create a burden in terms of staffing and physical resources as well as the actual photocopying, preparation time and postage costs. The Coroners' Courts Support Service felt that disclosure would be time consuming for coroners' officers and that any costs needed to be agreed nationally.

Some respondents felt that there would not be a huge increase in costs, with most of these highlighting the potential for electronic storage of information to minimise the additional burden. One coroner stated that they already disclosed information free of charge. Another respondent asked why information cannot be sent by email and questioned whether costs need be high with the majority of information held electronically.

Question 27

We do not propose that interested persons should have all disclosable material provided to them automatically, or that if one interested person requests disclosure it should automatically be sent to all others. We propose instead that they should be made aware firstly that they are entitled to request the information, and secondly that they are made aware of requests for disclosure made by other interested persons to the case. Do you agree with this approach? If not, please suggest an alternative.

Most respondents agreed that interested persons should be made aware of their right to request material. A number of respondents questioned whether it was realistic for interested parties to not all be issued with the same information, but the majority accepted that automatic disclosure to all interested parties once one party had made a request would be extremely burdensome to the coronial service. A small minority felt that automatic disclosure was appropriate, some suggesting at all times, whilst others in certain circumstances.

Most respondents agreed that the proposed approach struck the right balance between transparency for interested persons, and the need not to make the process of disclosure overly burdensome. The Coroners' Society emphasised the need for all PiPs to have the same rights and that they should be told that disclosure ahead of the inquest is an option. The Royal College of Pathologists, commenting specifically on autopsy reports, suggest that the procedure outlined was appropriate as it balanced the important need for autopsy reports to be readily available with the potentially distressing contents of the report. The Coroner's Officers Association also agreed, commenting that where there has been disclosure, other PiPs should be given the opportunity to request copies of the same documentation. A number of comments were made reinforcing the need for clear information to be provided about the rights of the bereaved and PiPs to ensure they are genuinely able to make use of disclosure.

Some respondents questioned the proposals. One coroner was not convinced that it would be fair to disclose documents to one interested party without automatically disclosing them to others. Inquest and the Inquest Lawyers Group were of the view that all interested parties should be given an automatic right of disclosure to assist them and remove some conflict from the hearing itself.

Question 28

What level of requests for information from other interested persons would you expect to see?

Although a number of responses suggested it was likely to be higher, it was difficult to predict and was likely to vary significantly from case to case and area to area.

There was a general feeling amongst respondents that it would be very difficult to predict what level of requests would be made and the type of information that would be requested. Most felt that the new provisions on disclosure were likely to lead to some increase in requests. One coroner suggested that in many cases that involved death in a public place (for example a road traffic case) there would be a demand for information. The National Offender Management Service suggested that in prison cases there was likely to be a high level of requests for information.

Question 29

How common is charging for disclosure in practice at present? Should we specify the circumstances in which a coroner can charge?

Coroners are currently prohibited from charging for pre-inquest disclosure, and practice varies for post-inquest. Most felt that clarity about when charges could be made would be helpful.

With respect to disclosure after an inquest there appear to be mixed views with different jurisdictions having different practices. The War Widows Association would like to see consistency when it comes to charging and would like clear information regarding the circumstances of when a coroner can charge for information. Members of the Local Authority Managers group for coroners in the South East and East Midlands do not currently charge for disclosure but if they were clear about when they could charge then they probably would.

Question 30

What levels of fees should be payable?

The vast majority suggested that this should be on a cost recovery basis, although some suggested a fixed fee and others did not feel there should be any charge.

There was a clear feeling amongst respondents that any charges should be on a cost recovery basis only and with no element of profit. One coroner suggested that it should be based on the full costs of transcription or photocopying charges but as reimbursement – there should be no profit element. The Coroner's Officers Association felt it was a matter for the local authority but on a standardised basis and on a not for profit basis. The Royal

College of Pathologists suggested that comparisons with other public sector bodies should be sought. Of those who did not put forward this view the most common suggestion was a fixed fee, either per page of photocopying, or a one off fee for all disclosure.

Question 31

To whom should the fee be paid? If paid to a coroner's office, should the fee be passed on to the relevant local authority?

The majority of respondents felt that the fees should be recoverable by whoever has the burden of providing the service.

There was a clear consensus that the fees should be paid to whoever provided the service. It was pointed out that this task was not always taken on by the local authority, but was sometimes taken on by the police or, in part-time jurisdictions, it may be taken on by the coroner themselves. One respondent pointed out that if the coroner's officer is employed by the police, then it would be them who should bear the cost burden of staff time and stationery etc.

Question 32

Once an investigation is completed, should we specify a time limit for obligation for requests to a coroner to disclose information – e.g. 6 months/a year after the conclusion of the investigation – so that after a certain period, a coroner will have discretion to refuse a request for information?

A majority were in favour of having no time limit although this was by no means a consensus, with a number arguing for time-limits of varying durations.

Although a majority were against a time limit there was not a consensus amongst respondents. The Coroners' Society suggested that there may be many reasons why others may require evidence from an inquest at a future date. A number of those who felt there should be no time limit did so because of the differing reactions grief can cause and it can therefore take some time before bereaved people approach the coroner for information about any given case.

Some felt that a time limit should be given. One respondent suggested that the time limit should be the same as for other medical records. Another, a coroner, suggested that a three month maximum was appropriate unless a case was made to the Chief Coroner for longer.

Chapter 6 – The conduct of the inquest

Background

This chapter invited comment on a wide range of issues relating to the conduct of the inquest. It set out the policy contained within the 2009 Act, and discussed the rules and regulations that would be needed in a reformed system. It was suggested that the requirement for a formal opening of an inquest was no longer required, discussed whether there was a need for greater clarity and/or flexibility about the admissibility of documentary evidence and discussed the need (or otherwise) for the current requirement that documents be retained for 15 years.

The chapter went on to discuss potential new rules. In broad terms, the discussion focussed on the following areas:

- 'Short form' and 'narrative' determinations ('verdicts' in the current system);
- A requirement for an inquest to be held promptly;
- The procedure for summoning witnesses;
- Whether to allow unsworn evidence to be accepted;
- How best to garner evidence from vulnerable or potentially vulnerable witnesses;
- Powers to withhold names or other matters not to be disclosed.

It finished by discussing areas of the current rules that were likely to be either altered or retained in the new system.

Question 33

Should a formal requirement for the opening of an inquest be retained?

Overall there were mixed views on this requirement being retained.

Many believed that formally opening an inquest allows the public and all interested parties to be aware that a formal legal inquiry into the death has begun. One respondent suggested that, whilst it may not be necessary to formally open an inquest, if the practice is abandoned it should be replaced with a clear and open decision that there is to be an inquest, and a clear statement of reasons as to why it cannot be held quickly.

The Media Lawyers Association, along with several other respondents from the media industry, made a more general point that all trials should be conducted, and all judgments given, in public and inquests should be no exception to that rule. They believed that this "open justice" principle encompasses the right of the media to freely report the proceedings to the general public.

Coroners were not in consensus when it came to this proposal. The Coroners' Society did not see the need for a formal opening - however, several individual

coroners sent responses indicating that they believe that the requirement should remain.

Question 34

Should there be a formal requirement for an inquest, when relevant, to be held as soon as possible after the death?

Overall there was support for a formal requirement.

Most respondents agreed that there should be a formal requirement for an inquest, when relevant, to be held as soon as possible after the death. Those bereaved family members and voluntary organisations who responded were particularly supportive of this proposal as it would allow families to begin their grieving process and allow other witnesses to the death closure on what they had experienced. Several respondents suggested that the words "as soon as possible" need to be replaced with "as soon as is reasonably practicable" as the latter phrase would take into account investigative delay and problems with accommodation issues that some coroners have.

Coroners were mixed in their opinion, with several supporting the proposal strongly while others disagreed. One was in favour because they thought that this would help coroners remind others to provide reports in a timely manner. However, another was concerned about not being able to meet this duty because of lack of court availability. Several coroners would like to see guidance from the Chief Coroner on this duty, while the Coroners' Society did not see the need for such a duty if the Chief Coroner was to be making provisions for improvements in coroner case management.

Question 35

Should the procedures for summoning witnesses be put on a more formal footing, in similar terms to those regarding the summoning of jurors, for example?

A number of differing views were put forward.

The majority of coroners, including the Coroners' Society, were not supportive of this proposal as they believe the current system works well. However, there was general agreement that if there is a need to introduce a summons system then it should be the same as the one used for jurors. Some bereaved family members and local authorities were very supportive of this proposal, as they believe that in the current system cases are delayed because witnesses do not attend or simply refuse to do so by, for example, going abroad. As a result, evidence from key witnesses ends up being lost. In their opinion, this proposal may compel more witnesses to attend. One response from a bereaved family was that there should be penalties imposed on witnesses for non-attendance at an inquest when summonsed. [NB this is provided for in the Act]

However, some voluntary organisations who work with the bereaved, such as Cruse Bereavement Care, feared that placing witness summoning on a more formal footing would be likely to make the process of giving evidence more distressing and intimidating for bereaved people. Their view was based on their experience of bereaved family members reporting to them that they had felt like they were on trial when giving evidence at an inquest, and had consequently been considerably distressed by the whole process.

Question 36

Should the circumstances when vulnerable or potentially vulnerable witnesses are to be granted special measures while giving evidence be put on a formal basis?

The majority agreed that guidance should be issued so national standards were in place.

The majority of respondents agreed that guidance should be issued by the Chief Coroner so that national standards were created and adhered to. However, several coroners, including the Coroners' Society, would like coroners to retain their power of discretion in this area.

A number of voluntary sector organisations were very supportive, and in particular felt that this would bring greater consistency to the way in which vulnerable witnesses were dealt with. Victim Support would ideally like an automatic availability of special measures for any witnesses who request it. However, if this is not possible, then they would like a proper system of needs assessment that identifies vulnerable and intimidated witnesses before the inquest and whatever special measures are necessary to be made available in court to cater for such witnesses.

Question 37

In what circumstances do consultees think coroners should exercise powers to withhold names or other matters?

A number of suggestions were put forward.

The majority of respondents were in favour of coroners being more sensitive to the needs of the bereaved when it comes to withholding names or other matters. However, the view was also expressed that, whilst there is a tension between the principles of open justice and an individual's privacy and security, openness and transparency should be the overriding factors in all but exceptional cases.

Circumstances suggested in which names could be withheld included:

- Where embarrassment can be caused to the individual;
- Where it is not in the public interest;
- Where there is a risk of danger to an individual's life;

- Where it is in the interests of national security and natural justice.

A few respondents suggested that items such as suicide notes should also be withheld as it could cause distress to younger members of the family.

The Media Lawyers Association stated their belief that this proposal may go far wider than was originally intended and are concerned that no provisions have been made with regards to legal challenges to such rulings or the need for reasons to be given for such orders being made. They also said that decisions to withhold addresses should only be made where there is proper evidence of a risk of safety to an individual or of interference with the administration of justice.

Question 38

Should there be a formal basis for coroners to accept unsworn evidence at inquests?

There is general agreement that coroners should be able to accept unsworn evidence in court in certain circumstances.

The majority of respondents agreed that a coroner should be allowed to accept unsworn evidence at inquests, particularly from children or those who do not have the capacity to understand the significance of being sworn under oath, as it would help speed up the process. However, a small minority felt that this decision should be left to the discretion of the coroner and that there was not a requirement for a formal procedure.

Question 39

Should the position on admissibility of documentary evidence be extended or clarified?

There is general agreement as to the need for the provisions on the admissibility of documentary evidence to be extended and clarified.

The majority of respondents, in particular coroners, would like the admissibility of documentary evidence to be extended and clarified, especially in relation to cases where the death occurred abroad and documentary evidence is often the only evidence available.

Question 40

Is there an argument for retaining or reducing the requirement for documents to be kept for 15 years as is the case at present – particularly in view of the new appeal arrangements against coroners' decisions which the Coroners and Justice Act 2009 establishes?

The general view is that the 15 year period for retaining inquest documents should remain.

The majority of respondents agreed that the period of retention of documents should be left at 15 years. It was pointed out that requests are often received years after the inquest, perhaps because at the time of death the properly interested person was only a child. It was also pointed out that, if new information comes to light about the circumstances of a death and the police wish to open, or re-open, an investigation, often the only proper record of the death and any previous investigation will be the coroner's file.

However, The National Archives believe that coroners records should be disposed of "when no longer needed" rather than after a fixed period, as this reflects the recommended good practice set out in the Lord Chancellors Code of Practice on the management of records, issued under s46 of the Freedom of Information Act 2000. Therefore, they believe the 15 year period should be reduced, although they understand that some documents should be kept for 15 years or even in rare circumstances considerably longer because they have archival value.

Question 41

Should a new list of short form determinations be established – and if so, what should the categories be?

There was a wide range of views expressed. On balance there was support for a new list of short form determinations to be introduced and for the new categories proposed in the consultation paper.

There were mixed views amongst the respondents in general, and amongst coroners in particular, about creating a new list of short form determinations. The Coroners' Society strongly disagreed with this proposal as they believe that coroners should retain their freedom to return a short form or narrative verdict depending on the individual case. However, there were several coroners who were in support of Michael Burgess's suggested list of short form verdicts included in the consultation paper. Two respondents also felt that the "misadventure" category is quite confusing and would like further clarification on its use. Cardiac Risk in the Young suggested that 'died from cardiac arrest with morphologically normal heart' should be added to the list.

The Office of National Statistics (ONS) said in their response that instead of using a limited list of short form determinations, it would be useful to ONS if coroners could complete tick boxes, for statistical purposes only, as

recommended by the World Health Organisation. According to ONS this form of system is already being practiced in many countries

Question 42

Should coroners be required to return a narrative determination in any case where they are unable to attribute one of these determinations?

On balance there was support for the use of narrative verdicts, although the problems this can cause for statisticians was noted.

Coroners in particular appeared to be in favour of this proposal. There were some who believed that narrative determinations are better than open verdicts; whilst there were others who believed that an open verdict is, in most cases, the appropriate option, but that the coroner should have the discretion to provide a narrative determination if he or she felt it to be necessary. Many voluntary organisations and pathologists were supportive of the greater use of narrative determinations, as it would in their view make the return of an open verdict redundant, and many of them find open verdicts to be very ambiguous.

The ONS was not supportive of the use of narrative verdicts, however, as the increase in their use has made it difficult to determine the cause and/or initial intent behind a growing number of deaths. If the use of narrative verdicts was to become the norm, the ONS would no longer be able to produce accurate statistics on deaths from suicides or accidents that were consistent and could be compared over time and by area.

Question 43

Should the rules contain something on the availability and use of narrative verdicts – and if so, what?

On balance there was support for some form of guidance on the use of narrative verdicts – so long as such guidance does not unduly fetter the judicial impartiality and discretion of the coroner.

Coroners are not supportive of the introduction of any such rules, as they believe they will make this area more complex than it already is, and feel that the current system works and that there is no need for change or guidance in this area. One suggested that they would like to see narrative verdicts given a regulatory standing, but that beyond this it should be left to coroners to deal with at their discretion.

Bereaved family members, voluntary organisations, and several other respondents were more favourable towards some form of guidance on the use of narrative verdicts. One said that the key issue was for the rules to ensure consistency over time and between coroners in the use of short form or narrative determinations. Inconsistencies over time may result in inaccurate assessment of trends and therefore the success or failure of preventive

efforts. Cardiac Risk in the Young supported guidance on the use of narrative determinations in cases of 'sudden young cardiac death'.

Question 44

We would welcome comments from respondents on any of the issues contained within the Coroners Rules 1984 that are likely, in substance, to be replicated in the new rules.

A number of suggestions were made.

The following were some of the rules that respondents would like us to look at and clarify:

- Rule 39 (notes of evidence)
- Rule 40 (addressing the coroner / jury as to the facts of the case)
- Rule 43 (reports to prevent future deaths)
- Rule 60 (forms)

A few respondents also suggested that the rules in general need to be modernised, and redrafted in clear and concise English.

Some respondents, including the Coroners' Society and a number of individual coroners, stated that they would like MoJ to consider the paper previously submitted by the Law Review & General Purposes Committee of the Coroners' Society when work starts on any redrafting of the Coroners Rules 1984.

Question 45

Are there any other areas where respondents suggest the Chief Coroner may consider issuing guidance in relation to the administration and conduct of inquests?

A number of suggestions were made.

The following were some of the suggestions that respondents would like the Chief Coroner to consider when issuing guidance:

- Whether he/she should have the power to intervene in disputes between coroners and local authorities over the provision of the requisite staff, resources and accommodation;
- Keeping families up to date on the progress of inquest cases;
- Provisions to be made for the recording and transcriptions of inquests;
- Relevant provisions under the Road Traffic Acts;
- Whether he/she should have the ability to issue practice directions when he or she sees fit to do so;
- Reading of reports verbatim in court;
- How witness statements should be used in inquests;

- Whether robes are necessary for coroners and advocates in formal proceedings.

Chapter 7 – Appeals and complaints

Background

This chapter made proposals for how an appeals system would work in a reformed system. It gave a summary of the provisions set out in the Act with regards to complaints and those areas that were able to be appealed.

It then set out a variety of aspects of an appeals system about which views were sought. These were:

- Whether a notice of appeal need be completed and what it should include;
- Whether the Chief Coroner may disregard an appeal considered frivolous or vexatious and whether the Chief Coroner should determine the method of considering appeal (i.e. whether there should be an oral or paper hearing);
- That the Chief Coroner should inform other interested persons about the appeal;
- Whether there should be timescales for an appeal and what those should be;
- What forms were necessary for the system, notices about costs and what avenues existed for onward appeals.

Question 46

Do you agree that the person who wishes to appeal must complete a notice of appeal in order for the Chief Coroner to consider the appeal?

Most respondents agree with this, although some suggested appropriate support for families would need to be provided

Respondents agreed almost unanimously that a notice of appeal should be completed. However, some pointed out that there was a need to make sure that families were appropriately supported, particularly where they did not have representation. Cruse Bereavement Care felt that provision would need to be made to assist those who may have difficulties in completing such paperwork.

Question 47

Do you agree that the notice of appeal should include a declaration that an attempt has been made to resolve the matter informally directly with the coroner or his office? If so, should this also apply where an appeal is about a post-mortem and therefore must be made within a very short timescale?

The vast majority of respondents agreed, although there were mixed views as to whether it would be possible for this to apply for post-mortem examination related appeals. Some also suggested that it may be inappropriate for certain types of decision.

There was popular support for a requirement for informal resolution prior to a formal appeal. The Criminal Bar Association pointed out that this would mirror the judicial review process and suggested that for post mortem appeals the process could be fast tracked, and a decision provided within forty eight hours. The Coroner's Officers Association agreed that a declaration should be included but that this may not apply for appeals relating to post mortem examinations. One coroner expressed the view that for a post-inquest appeal it is not open to the coroner or his/her staff to 'resolve' matters and there could not be a requirement on the coroner to explain his/her judicial decisions.

A few disagreed with proposals for informal resolution. For example, Action against Medical Accidents felt that this may provide an opportunity for coroners and coroners' officers to delay appeals.

Question 48

Do you agree that the Chief Coroner may disregard an appeal if he or she decides the appeal is vexatious or frivolous, and must document his reasons for doing so?

Most agreed with this proposal, with a number emphasising the need for clearly documented reasons as to why. A small number disagreed.

This proposal met with agreement from most respondents. One coroner suggested that the same principle should apply to an appeal that lacks obvious merit. The Health and Safety Executive suggested that this was particularly important where the appellant was simply trying to delay legal proceedings. One lawyer who responded felt that guidance on terminology would be helpful.

A small minority of respondents either questioned or disagreed with the need for this power. Inquest and the Inquest Lawyers Group stated that from their experience, they would not anticipate there being many appeals that would fall into the "vexatious or frivolous" category.

Question 49

Do you agree that the Chief Coroner will determine the method of considering the appeal – i.e. whether there should be a paper or oral hearing?

The majority of respondents agreed with this, although amongst groups representing the bereaved there was a high level of disagreement.

The majority of respondents agreed with this proposal. Coroners were strongly in favour, and most suggested that the coroner should be consulted prior to a final decision being taken. The Bereavement Advice Centre was supportive as long as reasons were given for the decision.

There was significant resistance to this proposal amongst voluntary organisations who felt that it limited the options for the bereaved. Action against Medical Accidents suggested that there should be an opportunity for the appellant to challenge the method of determination. Cruse Bereavement Care argued that some people may prefer an oral hearing and should be able to make the case for one.

Question 50

Do you agree the proposed timescales set out for lodging appeals and for the Chief Coroner to rule on appeals?

Most agreed that the timescales were appropriate.

The majority of respondents agreed with the timescales proposed. One coroner agreed but felt that the resource implications would be immense unless some senior coroners were delegated some appeals work in the status of acting deputy chief coroner. Another respondent suggested that the timescales were reasonable but that the system would need to emphasise the need for coroners to explain their decision directly and orally to the complainant.

The main area where there was disagreement on timescales was for post-mortem examination related appeals. A few felt that it was too 'loose' a description – for example, the Local Authority Managers groups for coroners in the South East and East Midlands argued that it should be 24 hours, rather than one working day because of weekends and bank holidays. Conversely, a few argued it was too short – a firm of solicitors suggested that five days would be more appropriate.

Chapter 8 – Training of coroners, their officers and staff

Background

This chapter sought views on the regulation and provision of training for those who work within the system. It set out tables with proposed training for coroners, their officers and staff. It also sought views on what, if any, training should be compulsory, who should deliver the training and how training should be delivered.

Question 51

We should be grateful for views on the tables at paragraph 10, which suggests training for coroners and their officers and staff. Do you agree with the content of the tables? Is there anything missing?

A number of suggestions were made.

There were a number of areas that respondents wanted to be covered, including media reporting of suicide, communication skills with bereaved families, prison procedures and policies and issues around military deaths.

Question 52

Should only some training be compulsory – if so what – e.g. induction training? Why?

The vast majority felt that induction should be compulsory, with a number suggesting that all training be compulsory.

There was strong support for induction training being made compulsory and a high number also suggesting that all training be compulsory. ACPO were in favour of compulsory induction, unless it can be demonstrated that the new post-holder has suitable knowledge from elsewhere. The Coroners Society argued that all training should be compulsory but recognised the high resource implications of this. They were strongly of the view that induction training was essential. Cruse Bereavement Care were of the opinion that induction training and continuing professional development (CPD) should be compulsory with CPD being based on an analysis of an individual's training needs.

Question 53

If compulsory, or part compulsory, should training have to happen before a coroner/officer/staff can operate, or within period of their beginning – say three or six months? Or should particular duties be exempt until training is received?

Most felt that induction training should be prior to someone taking up post and should be compulsory although a few felt this may not be realistic to implement. Other training need not be done prior to a person taking up their duties.

Nearly all respondents agreed that coroners and their staff would need to complete induction training before they begin carrying out their duties. Although supportive of this view the Coroners' Society felt it may be more realistic for a requirement that training must be completed within six months of appointment, to avoid a jurisdiction being without a coroner whilst a new appointee waits for the next training course. This point was also made by other coroners, although one suggested a time limit of within 12 months of appointment. Another suggested that a coroner should only be able to conduct certain types of inquests once they have obtained the correct training, giving the examples of prison deaths, active service deaths, mass fatality management and child deaths as inquests they should not be able to conduct without further training. Action against Medical Accidents was of the view that training for coroners should be consistent with the judiciary generally – that after appointment they should undergo training before they take up their posts.

Question 54

Should trainees have to complete a certain number of training days per year, or certain modules? What should the requirement be?

There was strong support for ongoing training with an element of compulsion, with a number of different suggestions as to how this could be achieved. The support for a specific number of training days was mixed.

There was strong support amongst respondents for some compulsion to ensure continuing professional development (CPD). However, there were mixed views as to the appropriate method to achieve this. One coroner felt that if the current cycle of residential training continued, then it should be necessary for a coroner to attend or to gain the equivalent in 'CPD' hours in training opportunities that may be available elsewhere. A firm of solicitors felt that was a need for a set amount of days, but that it was for the Coroners' Society, the Coroner's Officers Association and the Local Government Association to establish the precise requirement. Two coroners suggested that a system similar to that of the Tribunal Service involving a combination of required modules and training hours would be helpful.

Several respondents felt that this question was difficult to answer in detail without knowing what resources would be available. A number, particularly amongst coroners, felt that the question was impossible to answer without a commitment as to budget.

Question 55

If training is compulsory, what might be effective sanctions to ensure completion?

Strong support for some form of sanction, with a variety of suggestions as to the best method.

Most agreed that there was a need for sanctions with a range of options suggested from a system of self-certification (suggested by the Birmingham Law Society) to procedures which could, for continued non-compliance, lead to dismissal (cited by a number of respondents).

Question 56

What should happen if training is compulsory and someone cannot complete it – because of work commitments, illness or lack of authorisation from managers?

Sickness aside, most felt that work commitments or lack of authorisation from managers was unacceptable and some form of sanction should apply. In terms of sickness, most felt that they should be required to attend once well again.

Most felt that there needed to be a strong message about training that rendered non attendance because of work commitments, or lack of authorisation, unacceptable. However, the level of sanction supported in these cases varied significantly. Some suggested that this was a matter for the Chief Coroner to deal with. One suggestion was that a reduction in budget for the employer (where lack of authorisation applied) may be useful. The Coroners' Society suggested that some form of sanction may help to reduce these occurrences, but that it would be difficult to remove problems altogether and an element of flexibility was required – a number of coroners agreed with this response.

There was a greater mix of views in terms of sickness, although most felt that attendance should be required once someone was well again. One coroner's view was that an inability to attend compulsory training gave rise to questions about a person's capability to discharge coronial duties. Action against Medical Accidents suggested that there should be some discretion as sickness or maternity leave were reasonable reasons for not doing the training as soon as possible – a one year absence from work should trigger a requirement for refresher training.

Question 57

Assuming full induction has been received, should the minimum number of training days be the same for each category of person to be trained?

Although not universal, there was a level of support that training needs should be determined on an analysis of need for each role/individual and that the number of training days necessary is likely to differ.

The majority of respondents were in favour of training needs being assessed on an individual basis, although there was some support for the idea of a minimum number of days to apply to all. The Coroners' Society's view that training needs will differ was endorsed by a number of individual coroners who responded. Action against Medical Accidents were of the view that only coroners would need updates in the law and refresher courses. Cardiac Risk in the Young suggested that the more senior the position and responsibility the greater the number of days required. A number of respondents suggested that a full training needs analysis was necessary to identify requirements for either particular roles, or particular individuals.

Of those who felt the minimum number of days should be the same for all categories, most simply responded 'yes'. One respondent suggested that this approach would assist each category of person to know what others did which would be of use where colleagues were ill or otherwise absent.

Question 58

Who do you think would be best placed to deliver training and why?

A variety of providers were suggested. There was strong support for professional experts in the given area of training and in particular for coroners to be involved in the provision.

Although a number of different suggestions were made, there was strong support for the use of professional experts in the provision of training within the coronial service. Sudden Arrhythmic Death Syndrome UK suggested that trained coroners and coroners' officers would be best placed as they deal with situations on a daily basis and would have a thorough understanding of the theory and practice. Other seminars provided by organisations dealing with the bereaved may also be helpful. A number of coroners endorsed the Coroners' Society's approach of coroner led training. The Royal College of Pathologists suggested that a range of providers including private sector, further and higher education institutions should be considered.

There was also some support for training to be delivered by a national organisation with some consistent standards applied, with a mix of views as to whether the Chief Coroner, the MoJ or the Judicial Studies Board (JSB) were the most appropriate body to deal with this. Action against Medical Accidents felt that the JSB, with involvement from patient groups such as themselves, would be best. One coroner suggested the Chief Coroner was

best placed, building on the work of the Coroners Training Group with a mix of coroners and specialists in other fields delivering the training itself.

A number of respondents suggested specific organisations that should be consulted or called upon to help deliver specific aspects of training. These will be considered in due course.

Question 59

Should the Chief Corner approve a provider before they can train coroners, coroners' officers and support staff?

The majority felt that the Chief Coroner should approve the provider of the training, particularly if they are an outside provider. Most also wanted the Chief Coroner to approve the content of the training structure.

Question 60

Should there be a mix of providers, depending on the event?

The majority of respondents agreed with this proposal. However, a number of coroners objected to it.

Most respondents felt that this would be an appropriate approach. One coroner said that the Chief Coroner should provide basic training but otherwise there could be a mix of providers. The Independent Advisory Panel on Deaths in Custody suggested that any mix of providers would need to include voluntary organisations and bereaved family members. Cruse Bereavement Care felt that whilst it would depend on the event, it may be appropriate on some occasions.

However, of those coroners that responded, although not universal there were many who felt that this was the wrong approach. One suggested that it could be problematic and that there would need to be clear ownership of the delivery of the training. The Coroners' Society felt that this may be the worst option.

Question 61

Should training provide CPD credit for coroners?

The majority of respondents agree that training should provide CPD credit for coroners. Two coroners suggested that coroners should be required to achieve an annual minimum number of points

Question 62

Should there be training courses – possibly residential – for induction courses for coroners and officers; and CPD training.

Most were in favour, recognising the benefit of networking and the sharing of experience.

Residential training was welcomed by most. Although there was an acknowledgement that this can be time consuming and involves time away from the office, it was generally felt that some training (such as induction) could not be delivered any other way and that residential training provides the opportunity for networking and sharing experiences with others in an informal environment.

Question 63

Should there be on site locally delivered training – for local issues?

There was general support for this in principle, but some concern about ensuring consistency and some questioning of what a local issue would consist of.

The majority of respondents agree with this proposal in principle as many feel that this could be beneficial. There were some variations suggested to the proposal. One senior registration officer suggested a mentoring service for specific areas may be helpful – for example with local hospitals. The Coroners' Officers Association felt that, in order to ensure national standards, there should be joint training with local agencies rather than training on local issues.

A firm of solicitors suggested that any local training should be infrequent because of the need for national consistency. A few respondents were of the opinion that regional events may be more appropriate than local, both to help with consistency and provide some economies of scale.

Question 64

Should there be e-learning – for refresher training; updates on developments/changes; and information which it is useful to have permanently available to refer to?

The majority were supportive of using e-learning as many saw this as effective and value for money. However, most took the view that e-learning should not replace all other forms of training, as some essential training requires practical experience and therefore would not be suited to this method of learning.

Question 65

Should some types of training event be open to a mixed audience – e.g. coroners, their officers and other staff, medical examiners, medical examiner officers, local authority staff? If so, which?

There was a high level of support for allowing a mixed audience to attend some events with a number of suggestions as to what those should be.

There appears to be majority support for allowing a mixed audience to attend some training sessions depending on the event. The view of the Coroners' Society, endorsed by a number of coroners, was that that this should be without question but not all would be appropriate. ACPO suggested that this would be useful in developing a greater understanding of each other's roles. Cruse Bereavement Care were clear that there would be some topics that are relevant to a mixed audience. One respondent suggested that there was no need for prescription in this area and that if someone was able to attend and prepared to pay the fee they should be able to.

Question 66

Should coroners be expected to devise an initial induction package locally for new area and assistant coroners and/or for coroners' officers and staff, based on a central template provided by the Chief Coroner's office? Or do coroners believe this is not part of their role given that they do not have direct management responsibility for any of these groups?

General agreement that there needs to be some form of central co-ordination, but mixed views as to the extent to which coroners be responsible for delivery.

There was a general view amongst respondents that any local induction should not replace nationally delivered training. There was also strong support for coroner input into any induction training. However, concerns were expressed about the potential for local induction creating some inconsistency of training as well as a number of questions as to whether coroners should be responsible for this type of activity. Whilst some felt a central template delivered locally by the coroner was appropriate, others did not feel this was within the coroners remit and, assuming it did not replace national induction training, considered it likely to create duplication of time and effort.

Question 67

Are there any other issues the Chief Coroner should consider in drawing up training regulations?

A number of issues were raised, including the development of national benchmarks, consultation with the Coroners' Society, and the introduction of a formal appraisal system.

Chapter 9 – Death registration procedure

Background

Views were sought on whether a short death certificate (equivalent to that provided for births) would be useful; and the content of any short death certificate.

Question 68

Should an equivalent short death certificate be issued by a registrar of births and deaths free of charge for each death registered in England and Wales? Please include the reasons for your views.

There is general agreement regarding the introduction of such certificates but disagreement as to whether a fee should be charged for it or not.

Although not unanimous, overall there was support for short death certificates. Many also wanted to impose a fee for issuing such certificates. On the other hand, there were several respondents who would like to see a short form of the death certificate that is issued free of charge. The latter did not feel that this system should be different to that for births and believed that a short certificate would be more practical as it would allow the bereaved family to easily prove death where necessary instead of having to wait for the full certificate. Some registrars in particular disagreed with issuing short form certificates, as they were of the opinion that the current form of short certificates that are issued after birth are of no practical use, as many organisations still require a full version of the certificate.

The Local Government Panel for Registration in England and Wales supported the view that a short death certificate should be made available but not free of charge. The option of a short certificate would offer the choice to bereaved families who may or may not want copies with cause of death to be shown. In their opinion, an extract certificate, more in line with the civil partnerships extract certificate, may be the example to follow. They also suggested that the cost should be in line with the General Register Office fees. Their reasoning was that at present, the disposal document (Form 9) and BD8 Form for the Department of Work and Pensions are already issued without charge. They also pointed out that the current short birth certificate is of little use as it is no longer accepted by many organisations or government bodies.

Question 69

Should a short certificate omit any information about the occupation and other details of the person who has died, and the person who has authorised registration of the death?

There is general agreement that such information could be omitted from such certificates.

Most respondents were of the opinion that the proposed information ought to be omitted from the death certificate. Bereaved family members were largely in support of this view as they believed the information concerned was personal and did not need to be on the certificate. The Local Government Panel also agreed that the short death certificate could omit some of this information e.g. occupation and cause of death. They also suggested a further consultation should be undertaken with the banks, utility and insurance companies to understand their requirements. However, they were concerned that by issuing two different types of certificate, it could cause confusion for the bereaved as they would not know who would accept what.

Those respondents that disagreed with the proposal, who were generally registrars, believed that such information was essential, as you still needed to identify the person who has died and often such information was needed to confirm and verify the relationship of the deceased to the informant.

Conclusion and next steps

The consultation responses showed a wide range of views about the best way forward for coroner reform. This section gives a brief summary of which parts of this consultation the Government intends to take forward, in the light of responses received and the Written Ministerial Statement (WMS) made to Parliament.

Chapter 1: Deaths to be reported to a senior coroner

This is likely to be taken forward. Responses generally agreed with the categories suggested for reporting, that there should be an extended time limit for doctors to certify and that there should be recourse to the General Medical Council for those medical practitioners who repeatedly fail to report deaths. The Ministry of Justice will work with the Department for Health (who are taking forward the creation of Medical Examiners) and other interested parties to develop regulations and associated guidance that will set out those categories of death that must be reported. We will consult on the regulations in due course.

Chapter 2: Transferring cases from one coroner area to another

Responses supported the principle that transfer should be available in the way described in the Act. There were mixed views as to who should pay where a case has been transferred and about the process for transfer. In line with the Government's announcement that it is not, in the present circumstances, viable to create the post of Chief Coroner, consideration is being given to who is best placed to take on this responsibility. If it is agreed, the Ministry of Justice will work with interested parties to gain agreement on the detail of the process for transfer.

Chapter 3: Post-mortem examinations and retention of bodies

This is likely to be taken forward. There were a number of views expressed about post-mortem examinations and the retention of tissue. Taking into account this feedback, the Government will establish what work is required, including what secondary legislation and guidance is required.

Chapter 4: Coroner investigations – entry, search and seizure

A number of views were expressed about the most appropriate way for a system of entry, search and seizure to be operated. However, in line with the WMS, the Government will only be implementing those provisions in the Act which are expected to be cost-neutral and will not, therefore, be commencing these powers at the current time.

Chapter 5: Disclosure of information by coroners

There was broad support for the principle of greater disclosure but a number of views were expressed about the detail of a disclosure scheme. The Government taking forward in developing secondary legislation, and taking into account the responses received, will work with all those with an interest to establish the most consensual way forward.

Chapter 6: The conduct of the inquest

Most of the issues consulted on are likely to be taken forward. In developing rules that govern the conduct of an inquest, the Ministry of Justice will take into account the wide variety of responses received. We will consult on those rules in due course.

Chapter 7: Appeals and complaints

A number of different views were expressed about the way in which an appeals system should operate. However, in line with the WMS, the Government will not be implementing an appeals system. A complaints system will be considered as part of the work we intend to take forward on a Charter for Bereaved People.

Chapter 8: Training of coroners, their officers and staff

This is likely to be taken forward in part. The Government welcomes the broad support offered to the principle that coroners, coroners' officers and other staff who work in the system need appropriate training. There were a number of helpful suggestions given in response to the consultation that will be taken into account in developing the content of this training.

Chapter 9: Death registration procedure

Responses have been forwarded to the General Register Office who are considering how and when a short death certificate will be introduced.

Consultation co-ordinator contact details

If you have any complaints or comments about the consultation **process** rather than about the topic covered by this paper, you should contact Julia Bradford, Ministry of Justice Consultation Co-ordinator, on 020 3334 4492, or email her at consultation@justice.gsi.gov.uk.

Alternatively, you may wish to write to the address below:

Julia Bradford
Consultation Co-ordinator
Ministry of Justice
102 Petty France
London SW1H 9AJ

If your complaints or comments refer to the topic covered by this paper rather than the consultation process, please direct them to the contact given under the **Contact details** section of this paper at page 3.

The consultation criteria

The seven consultation criteria are as follows:

1. **When to consult** – Formal consultations should take place at a stage where there is scope to influence the policy outcome.

2. **Duration of consultation exercises** – Consultations should normally last for at least 12 weeks with consideration given to longer timescales where feasible and sensible.

3. **Clarity of scope and impact** – Consultation documents should be clear about the consultation process, what is being proposed, the scope to influence and the expected costs and benefits of the proposals.

4. **Accessibility of consultation exercises** – Consultation exercises should be designed to be accessible to, and clearly targeted at, those people the exercise is intended to reach.

5. **The burden of consultation** – Keeping the burden of consultation to a minimum is essential if consultations are to be effective and if consultees' buy-in to the process is to be obtained.

6. **Responsiveness of consultation exercises** – Consultation responses should be analysed carefully and clear feedback should be provided to participants following the consultation.

7. **Capacity to consult** – Officials running consultations should seek guidance in how to run an effective consultation exercise and share what they have learned from the experience.

These criteria must be reproduced within all consultation documents.

Annex A: List of respondents

Coroners, coroner's officers and staff

The Coroners' Society of England and Wales

Coroners Officer's Association

The Greater Manchester Coroners – (John Pollard, Nigel Meadows, Simon Nelson and Jennifer Leeming)

Ian Arrow - HM Coroner for Torbay and South Devon

Robin Balmain - HM Coroner for Black Country

Peter Bedford - HM Coroner for Berkshire

John Broadbridge - HM Deputy Coroner for North Yorkshire (East)

Tony Brown - HM Coroner for North Northumberland

Michael Burgess - HM Coroner for Surrey and Coroner of the Queens Household

Dr Emma Carlyon - HM Coroner for Cornwall

Dr Nigel Chapman - HM Coroner for Nottinghamshire and Nottingham City

Rodney Corner - HM Coroner for Milton Keynes

Alan Crickmore - HM Coroner for Gloucestershire

Rachel Davies - Coroners officer

Malcolm Donnelly - HM Coroner for Hartlepool

Christopher Dorries - HM Coroner for South Yorkshire (West)

Dr Elizabeth Earland- HM Coroner for Exeter & Greater Devon District

John Ellery - HM Coroner for Mid and North-West Shropshire

Andrew Haigh - HM Coroner for South Staffordshire

Andrew Harris - HM Deputy Coroner for Inner South London

Mary Hassell - HM Coroner for Cardiff & The Vale of Glamorgan

Michael Howells (retired coroner)

Christopher Johnson - HM Coroner for Merseyside (Wirral District)

Dr Paul Knapman - HM Coroner for Inner West London

Ms C J Lake - Coroners officer

Jennifer Leeming - HM Coroner for Greater Manchester West

Jim Lewis – Chief Clerk at HM Coroners Court

Peter Maddox - HM Coroner for Bridgend and the Glamorgan Valleys and Powys
David Masters - HM assistant Deputy Coroner for Wiltshire and Swindon
Paul Matthews - HM Coroner for the City of London
Sean McGovern - HM Coroner for Coventry & Warwickshire
Nigel Meadows - HM Coroner for the City of Manchester
David Mitford - HM Coroner for Newcastle upon Tyne
Caroline Beasley-Murray (HM Coroner for Essex and Thurrock) and Veronica Hamilton-Deeley (HM Coroner for Brighton and Hove) - Joint response
Michael Oakley - HM Coroner for North Yorkshire (Eastern District)
Dr Roy Palmer - HM Coroner for South London
Andre Rebello - HM Coroner for the City of Liverpool
Rachel Redman – HM Coroner for Central and South East Kent
David Ridley - HM Coroner for Wiltshire & Swindon
David Roberts - HM Coroner for North and West Cumbria
Philip Rogers - HM Coroner for City & County of Swansea and Neath Port Talbot
Gordon Ryall - HM Coroner for Peterborough
Geoff Saul - HM Coroner for Kingston upon Hull and East Riding of Yorkshire
Michael Singleton - HM Coroner for Blackburn, Hyndburn and Ribble Valley
Grahame Short - HM Coroner for Central Hampshire
Ian Smith - HM Coroner for South and East Cumbria
Ian Smith - HM Coroner for Stoke-on-Trent & North Staffordshire
Dr Elizabeth Stearns - HM Coroner for Eastern London
Maureen Taylor - HM Coroner for Boston and Spalding
Edward Thomas - HM Coroner for Hertfordshire
Andrew Tweddle - HM Coroner for Durham
Andrew Walker - HM Coroner for North London
Roger Whittaker - HM Coroner for West Yorkshire (Western District)
Geraint Williams - HM Coroner for Worcestershire
Derek Winter - HM Coroner for the City of Sunderland

Voluntary organisations working with bereaved people

Action against Medical Accidents (AvMA)

Alice Barker Trust

Anglo-Asian Friendship Society

Association Bereavement Service Coordinators

Bereavement Advice Centre

British Heart Foundation

Cardiac Risk in the Young (CRY)

CO-Gas Safety

Coroners' Courts Support Service

Cruse Bereavement Care

Inquest and the Inquest Lawyers Group

Missing People

RoadPeace

Saad Foundation

SADS UK (Sudden Arrhythmic Death Syndrome)

Southeast Asbestos Awareness and Victims Support Group

The British Lung Foundation

The Compassionate Friends

The Royal British Legion

Victim Support

Victims Voice

War Widows Association of Great Britain

Pathology profession

Royal College of Pathologists

British Paediatric Pathology Association

Dr Mark Hayes - Consultant Histopathologist

Dr Michael Jarmulowicz - Pathologist

Professor James Lowe - Consultant pathologist

Ruth Musson – Pathology specialist nurse

Dr Michael Osborn - Consultant Histopathologist

Dr Rosemary Scott – Consultant Perinatal Pathologist

Professional organisations involved in death certification

Buckinghamshire County Council – The Register Office
Cheshire West and Chester Council – The Register Office
Darlington Register Office
Hull Register Office
Lancashire Registration Service
Local Goverment Panel for Registration (England and Wales)
London Borough of Hounslow – The Register Office
Lincolnshire County Council – The Register Office
Manchester Beth Din - Jewish Ecclesiastical Court
Norwich District Register Office
Sheffield Register Office
Registration Services Solihull MBC
Sandwell Register Office
Sunderland Registration Services
West Sussex Registration Service
Wiltshire Registration Service

Local Authorities

Association of Chief Archivists in Local Government
Bristol City Council
Hampshire County Council
Kingston upon Hull and East Riding of Yorkshire Councils
Lancashire County Council
Midlands and Eastern Region Group and South Eastern Group
Powys County Council

Other Investigating Authorities

General Medical Council
Health and Safety Executive
Human Tissue Authority
Independent Police Complaints Commission
Office of Rail Regulation
Prison and Probation Ombudsman

Bereaved People

Anonymous

Nina Baker

Tony and Yvonne Brown

Jay Calascione

Kate Carpenter

Teresa Evans

Elaine Isaacs

Alick Moore

Rhiannon Smith

Nicole and Christopher Taylor

Medical Profession

British Medical Association

Royal College of Physicians of Edinburgh

Royal College of Radiologists

Faculty of Forensic and Legal Medicine of the Royal College of Physicians

G4S Forensic and Medical Services

Great Ormond Street Children's Hospital (NHS Trust) - End of Life Care

Dr Pierre-Antoine Laloe

Government and Non-Departmental Public Bodies

Department for Communities and Local Government - Expenditure Control Team

Independent Advisory Panel on Deaths in Custody

National Offender Management Service - Offender Safety, Rights & Responsibilities Group

National Policing Improvement Agency Missing Persons Bureau

National Suicide Prevention Strategy Advisory Group

Office for National Statistics

The National Archives

Police Authorities

Association of Chief Police Officers

West Yorkshire Police

Legal Profession

Association of Personal Injury Lawyers

Beachcroft LLP

Berrymans Lace Mawer LLP

Birmingham Law Society

Browne Jacobson LLP

Criminal Bar Association

Forum of Insurance Lawyers

Kennedys Solicitors

London Criminal Courts Association

Motor Accident Solicitors Society

Thompson Solicitors

Medical Defence Organisations

Medical Defence Union

Medical Protection Society

Media Organisations

Associated Newspapers Limited

Channel Five Broadcasting Limited

Press Association

Society of Editors

The Guardian News and Media Ltd

The Independent and the Independent on Sunday

The Media Lawyers Association

The Newspaper Society

Times Newspapers Ltd

Trinity Mirror Plc

Individuals

John Cresswell

Professor David Gunnell

Deborah Henderson

Dr Lanny Hobson

Dr Stephen Leadbeatter

Tom Luce

Ranu Rowan

Guy Singleton

Anne Smith

Nicolas Wheatley

Faith Groups

Board of Deputies of British Jews

Bolton Council of Mosques

Council for Mosques (Bradford)

Muslim Burial Council of Leicestershire

David Thewlis and Stuart Taylor (on behalf of The Brethren Christian Fellowship)

Others

BUPA Care Homes

London Criminal Courts Association

London School of Hygiene and Tropical Medicine

Network Rail

The Howard League for Penal Reform

Produced by the Ministry of Justice

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or telephone 020 3334 6403